

**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF NORTH CAROLINA  
SOUTHERN DIVISION  
No. [ ]:[ ]-[ ]-[ ]-[ ]-[ ]**

**IN RE: CAMP LEJEUNE  
WATER LITIGATION**

\_\_\_\_\_/

**THIS DOCUMENT RELATES TO:**

**DISCOVERY POOL PROFILE  
FORM**

XXXXXX	X	XXXXXX	XX
Plaintiff First	Middle	Last	Suffix

In completing this Discovery Pool Profile Form (“DPPF”), you must provide information that is true and accurate to the best of your knowledge. In completing this DPPF, you are under oath and subject to the penalties of perjury. The DPPF shall be completed pursuant to the September 26, 2023 *Case Management Order No. 2*. (Doc. 23). Plaintiff reserves the right to supplement all responses. For each question where the space provided does not allow for a complete answer, please attach additional sheets so that all answers are complete. Please answer each question and do not leave any blanks. If appropriate, you may respond in good faith that you do not know or do not recall. If you do not know or do not recall the information requested, please provide as much information as you can. All aspects of this DPPF are designated as “Confidential Information” and covered by the Protective Order, D.E. 36.

1. What is the DON Claim Number for the administrative claim (Short Form Complaint, Box 30)?  E.g., CLS23-123456		<div>[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]</div> <div><input type="checkbox"/> DON has not yet assigned a claim number</div>	
2. Who is completing this Discovery Pool Profile Form?		<div><input type="checkbox"/> Plaintiff or Plaintiff's Agent</div> <div><input type="checkbox"/> Attorney for Plaintiff or Attorney for Plaintiff's Agent</div>	
If this Discovery Pool Profile Form is being completed by an attorney, please identify the attorney:			
3. Attorney first name			
4. Attorney last name			
5. Law firm name			
6. Attorney address line 1			
7. Attorney address line 2			
8. Attorney city			
9. Attorney state (abbrev.)		<div>[ ][ ]</div>	
10. Attorney zip code		<div>[ ][ ][ ][ ][ ][ ]</div>	
11. Attorney phone		<div>([ ][ ][ ]) [ ][ ][ ] - [ ][ ][ ][ ]</div>	
12. Attorney email			
Resume universal questions			
13. What is the case number?  E.g., 7:23-cv-12345		<div>[ ]:[ ][ ][ ]-cv-[ ][ ][ ][ ][ ]</div>	
14. Which District Judge is assigned to the case?		<div><input type="checkbox"/> Hon. Richard E. Myers II</div> <div><input type="checkbox"/> Hon. Terrence W. Boyle</div> <div><input type="checkbox"/> Hon. Louise W. Flanagan</div> <div><input type="checkbox"/> Hon. James C. Dever III</div>	
15. Please identify any other names the Plaintiff has used, if different from that in the case caption (e.g., maiden name).			
16. Please identify the Plaintiff's Social Security Number.		<div>[ ][ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ][ ]</div>	
17. Please identify the Plaintiff's date of birth.		<div>_____ MM/DD/YYYY</div>	
18. Please identify the Plaintiff's last known address:			
18a. Street Address	18b. Town	18c. State (abbrev.)	18d. Year residence began (YYYY)
19. If the Plaintiff began residing at the above address after 2020, please identify the next most recent address:			
19a. Street Address	19b. Town	19c. State (abbrev.)	19d. Year residence began (YYYY)
20. On your Short Form Complaint, did you assert a claim for injuries to YOU or to SOMEONE ELSE you legally represent? (Box 1)		<div><input type="checkbox"/> To Me</div> <div><input type="checkbox"/> Someone Else</div>	

If you assert a claim for injuries to SOMEONE ELSE, please describe your representation of that person:					
21. What is the nature of the representative's representation?				<input type="checkbox"/> Estate Administrator/trix <input type="checkbox"/> Guardianship <input type="checkbox"/> Conservatorship <input type="checkbox"/> Power of attorney <input type="checkbox"/> Other: _____	
22. Has a court appointed you as the claimant's representative?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
23. If yes, please describe your appointment:					
23a. Court Name	23b. Court State (abbrev.)		23c. Date of appointment		
Resume universal questions					
24. <b>On your Short Form Complaint</b> , did you assert that the Plaintiff is deceased? (Box 7)				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If the Plaintiff is deceased:					
25. How many dependents, if any, did Plaintiff have at the time of Plaintiff's death?				<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6+ <input type="checkbox"/> I do not know/do not recall	
26. Please identify Plaintiff's spouse and children at the time of death. If none, check here: <input type="checkbox"/> No Spouse or Children at time of death					
26a. First name	26b. Middle Name	26c. Last name	26d. Suffix	26e. Relationship to Plaintiff	26f. Year of birth
<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	_____ YYYY <input type="checkbox"/> I do not know/do not recall
<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	_____ YYYY <input type="checkbox"/> I do not know/do not recall

<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	_____ YYYY <input type="checkbox"/> I do not know/do not recall
<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	_____ YYYY <input type="checkbox"/> I do not know/do not recall
<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	_____ YYYY <input type="checkbox"/> I do not know/do not recall

## II. MILITARY SERVICE & DEPENDENT MEDICAL

### a) Military service

Resume universal questions	
27. Has Plaintiff <i>ever</i> served in a branch of the U.S. military?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall
If the Plaintiff has previously served in the U.S. military:	
28. Did the Plaintiff's service <b>overlap</b> with any of the following conflict periods?	<input type="checkbox"/> WWI <input type="checkbox"/> WWII <input type="checkbox"/> Korea <input type="checkbox"/> Vietnam <input type="checkbox"/> Persian Gulf <input type="checkbox"/> Other: _____ <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A (e.g., only served during peacetime)

29. What was the Plaintiff's service number?			_____ <input type="checkbox"/> N/A (e.g., service after 1970) <input type="checkbox"/> I do not know/do not recall
30. For each period of service, please identify:			
30a. Service Branch	30b. Year service began	30c. Year service ended	30d. Officer or Enlisted
<input type="checkbox"/> Marine Corps <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard	_____ YYYY <input type="checkbox"/> I do not know/do not recall	_____ YYYY <input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Officer <input type="checkbox"/> Enlisted <input type="checkbox"/> Both <input type="checkbox"/> I do not know/do not recall
<input type="checkbox"/> Marine Corps <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard	_____ YYYY <input type="checkbox"/> I do not know/do not recall	_____ YYYY <input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Officer <input type="checkbox"/> Enlisted <input type="checkbox"/> Both <input type="checkbox"/> I do not know/do not recall
<input type="checkbox"/> Marine Corps <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard	_____ YYYY <input type="checkbox"/> I do not know/do not recall	_____ YYYY <input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Officer <input type="checkbox"/> Enlisted <input type="checkbox"/> Both <input type="checkbox"/> I do not know/do not recall
<input type="checkbox"/> Marine Corps <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard	_____ YYYY <input type="checkbox"/> I do not know/do not recall	_____ YYYY <input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Officer <input type="checkbox"/> Enlisted <input type="checkbox"/> Both <input type="checkbox"/> I do not know/do not recall

*b) Veteran and dependent medical*

<b>Resume universal questions</b>	
31. Is/was Plaintiff a TRICARE beneficiary?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall
<b>If the Plaintiff is or was a TRICARE beneficiary:</b>	
32. Did someone else sponsor the Plaintiff's TRICARE benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall
<b>If someone else sponsored the Plaintiff's TRICARE Benefits</b>	
33. Sponsor/Veteran First Name	_____
34. Sponsor/Veteran Middle Name	_____
35. Sponsor/Veteran Last Name	_____
36. Sponsor/Veteran SSN	[ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ] <input type="checkbox"/> I do not know/do not recall

37. Sponsor/Veteran Branch of Service	<input type="checkbox"/> Marine Corps <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Coast Guard <input type="checkbox"/> I do not know/do not recall
38. Claimant relationship with Sponsor/Veteran	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Mother-in-law <input type="checkbox"/> Mother-in-law <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other: _____ <input type="checkbox"/> I do not know/do not recall

*Other Service/Employment*

Resume universal questions		
39. On your Short Form Complaint, did you assert that the Plaintiff was a <b>Civilian Employee of a Private Company</b> at Camp Lejeune? (Box 17)		<input type="checkbox"/> Yes <input type="checkbox"/> No
40. [If yes] Please identify:		
40a. Plaintiff's Employer (Private Company)	40b. Date employment began	40c. Date employment ended
_____	_____	_____
<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall
_____	_____	_____
<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall
_____	_____	_____
<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall
41. On your Short Form Complaint, did you assert that the Plaintiff was a <b>Civil Service Employee</b> at Camp Lejeune? (Box 17)		<input type="checkbox"/> Yes <input type="checkbox"/> No
42. [If yes] Please identify:		
42a. Plaintiff's Employer (Agency)	42b. Date employment began	42c. Date employment ended
_____	_____	_____
<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall

_____	_____	_____
<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall
_____	_____	_____
<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall

### III. DISEASES AND ILLNESSES

Resume universal questions	
<p>43. What diseases or injuries does the claimant assert are related to exposure to water at Camp Lejeune? (choose all that apply)</p>	<div> <input type="checkbox"/> Bladder cancer  <input type="checkbox"/> Kidney cancer  <input type="checkbox"/> Leukemia  <input type="checkbox"/> Non-Hodgkin's lymphoma  <input type="checkbox"/> Parkinson's disease  <input type="checkbox"/> Adverse Birth Outcomes  <input type="checkbox"/> ALS  <input type="checkbox"/> Aplastic anemia or myelodysplastic syndromes  <input type="checkbox"/> Bile duct cancer  <input type="checkbox"/> Brain/CNS cancer  <input type="checkbox"/> Breast cancer  <input type="checkbox"/> Cardiac birth defects  <input type="checkbox"/> Cervical cancer  <input type="checkbox"/> Colorectal cancer  <input type="checkbox"/> Gallbladder cancer  <input type="checkbox"/> Hepatic steatosis  <input type="checkbox"/> Hypersensitivity skin disorder  <input type="checkbox"/> Infertility  <input type="checkbox"/> Intestinal cancer  <input type="checkbox"/> Non-cancer kidney disease  <input type="checkbox"/> Leukemia  <input type="checkbox"/> Liver cancer  <input type="checkbox"/> Lung cancer  <input type="checkbox"/> Multiple myeloma  <input type="checkbox"/> Neurobehavioral effects  <input type="checkbox"/> Non-cardiac birth defects  <input type="checkbox"/> Ovarian cancer  <input type="checkbox"/> Pancreatic cancer  <input type="checkbox"/> Prostate cancer  <input type="checkbox"/> Sinus cancer  <input type="checkbox"/> Soft tissue cancer  <input type="checkbox"/> Systemic sclerosis/scleroderma  <input type="checkbox"/> Thyroid cancer  <input type="checkbox"/> Other: _____ </div>

a) Injury 1 – repeat questions for each injury asserted

<p>44. I am completing this section as it relates to:</p>	<p> <input type="checkbox"/> Bladder cancer  <input type="checkbox"/> Kidney cancer  <input type="checkbox"/> Leukemia  <input type="checkbox"/> Non-Hodgkin's lymphoma  <input type="checkbox"/> Parkinson's disease  <input type="checkbox"/> Adverse Birth Outcomes  <input type="checkbox"/> ALS  <input type="checkbox"/> Aplastic anemia or myelodysplastic syndromes  <input type="checkbox"/> Bile duct cancer  <input type="checkbox"/> Brain/CNS cancer  <input type="checkbox"/> Breast cancer  <input type="checkbox"/> Cardiac birth defects  <input type="checkbox"/> Cervical cancer  <input type="checkbox"/> Colorectal cancer  <input type="checkbox"/> Gallbladder cancer  <input type="checkbox"/> Hepatic steatosis  <input type="checkbox"/> Hypersensitivity skin disorder  <input type="checkbox"/> Infertility  <input type="checkbox"/> Intestinal cancer  <input type="checkbox"/> Non-cancer kidney disease  <input type="checkbox"/> Leukemia  <input type="checkbox"/> Liver cancer  <input type="checkbox"/> Lung cancer  <input type="checkbox"/> Multiple myeloma  <input type="checkbox"/> Neurobehavioral effects  <input type="checkbox"/> Non-cardiac birth defects  <input type="checkbox"/> Ovarian cancer  <input type="checkbox"/> Pancreatic cancer  <input type="checkbox"/> Prostate cancer  <input type="checkbox"/> Sinus cancer  <input type="checkbox"/> Soft tissue cancer  <input type="checkbox"/> Systemic sclerosis/scleroderma  <input type="checkbox"/> Thyroid cancer  <input type="checkbox"/> Other: _____         </p>
<p>45. Has a physician diagnosed the Plaintiff with this injury?</p>	<p> <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> I do not know/do not recall  <input type="checkbox"/> N/A         </p>
<p>46. If yes, when was Plaintiff first diagnosed this injury?</p>	<p>           _____            MM/DD/YYYY  <input type="checkbox"/> I do not know/do not recall  <input type="checkbox"/> N/A         </p>



47. Name of physician that first diagnosed the Plaintiff?				_____ Name <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A			
48. Name of hospital or medical group of physician:				_____ Name <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A			
49. Do you allege that this Injury caused or contributed to the Plaintiff's death?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A			
50. List all treating physicians, name of medical group, and city, state where treatment was received. If none, check here: <input type="checkbox"/> No treatment.							
50a. First name, if known	50b. Middle Initial, if known	50c. Last name, if known	50d. Suffix, if known	50e. Medical Group	50f. City, State	50g. Year(s) of Treatment	50h. Was this covered by TRICARE
						_____ Years <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A

#### IV. EXPOSURES

Resume universal questions	
51. Please select all of the types of exposure you allege:	<input type="checkbox"/> Residential (living on-base) <input type="checkbox"/> Occupational (working on-base) <input type="checkbox"/> In utero <input type="checkbox"/> Other (e.g., visiting/recreation)

<p>52. Please select all of the areas on base in which Plaintiff lived.</p>	<p><input type="checkbox"/> Tarawa Terrace (includes Tarawa Terrace I, Tarawa Terrace II, Camp Knox Trailer Park)</p> <p><input type="checkbox"/> Hadnot Point (includes Mainside barracks, French Creek, and Hospital Point)</p> <p><input type="checkbox"/> Montford Point (includes Camp Johnson)</p> <p><input type="checkbox"/> Holcomb Boulevard (includes Berkeley Manor, Midway Park, Paradise Point, Watkins Village)</p> <p><input type="checkbox"/> Courthouse Bay</p> <p><input type="checkbox"/> New River Air Station (includes MCAS New River and Camp Geiger);</p> <p><input type="checkbox"/> Onslow Beach</p> <p><input type="checkbox"/> Rifle Range</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> I do not know/do not recall</p> <p><input type="checkbox"/> N/A</p>
<p>53. Was the Plaintiff <b>residing with a servicemember</b> during the period of exposure (e.g., parent or spouse), including in utero exposures?</p>	<p><input type="checkbox"/> Yes, residing with a servicemember parent</p> <p><input type="checkbox"/> Yes, residing with a servicemember spouse</p> <p><input type="checkbox"/> Yes, residing with someone else who was a servicemember</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> I do not know/do not recall</p>
<p>54. If the Plaintiff was residing with a servicemember during the period of exposure, please identify the servicemember:</p>	
<p>55. Servicemember First Name</p>	
<p>56. Servicemember Middle Name</p>	
<p>57. Servicemember Last Name</p>	
<p>58. Servicemember SSN</p>	<p>[ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ]</p> <p><input type="checkbox"/> I do not know/do not recall</p>
<p>59. Servicemember Date of Birth</p>	<p>_____ MM/DD/YYYY</p> <p><input type="checkbox"/> I do not know/do not recall</p>
<p>60. Servicemember Branch of Service</p>	<p><input type="checkbox"/> Marine Corps</p> <p><input type="checkbox"/> Army</p> <p><input type="checkbox"/> Navy</p> <p><input type="checkbox"/> Air Force</p> <p><input type="checkbox"/> Coast Guard</p> <p><input type="checkbox"/> I do not know/do not recall</p>

61. Servicemember Service Number	<p>_____</p> <input type="checkbox"/> N/A (e.g., service after 1970) <input type="checkbox"/> I do not know/do not recall
62. Claimant relationship with Servicemember at the time of exposure.	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Mother-in-law <input type="checkbox"/> Mother-in-law <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other: _____ <input type="checkbox"/> I do not know/do not recall
<b>Complete this section only if alleging <i>in utero</i> exposures:</b>	
63. Please select all of the areas on base in which <b>Plaintiff's mother</b> lived when the Claimant was in utero:	<input type="checkbox"/> Tarawa Terrace (includes Tarawa Terrace I, Tarawa Terrace II, Camp Knox Trailer Park) <input type="checkbox"/> Hadnot Point (includes Mainside barracks, French Creek, and Hospital Point) <input type="checkbox"/> Montford Point (includes Camp Johnson) <input type="checkbox"/> Holcomb Boulevard (includes Berkeley Manor, Midway Park, Paradise Point, Watkins Village) <input type="checkbox"/> Courthouse Bay <input type="checkbox"/> New River Air Station (includes MCAS New River and Camp Geiger) <input type="checkbox"/> Onslow Beach <input type="checkbox"/> Rifle Range <input type="checkbox"/> Other: _____ <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A
64. Did Plaintiff's mother work at Camp Lejeune as a <b>federal civilian employee</b> when the claimant was in utero?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall
65. If yes, what was the name of the government employer?	<p>_____</p> <input type="checkbox"/> I do not know/do not recall

## V. PERSONAL HISTORY

Resume universal questions	
66. Was the Plaintiff ever exposed to Agent Orange?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall

67. Was the Plaintiff ever exposed to open air burn pits?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall
68. Other than time spent residing at Camp Lejeune, was the Plaintiff ever employed in any of the following occupations? Check all that apply.	<input type="checkbox"/> Dry cleaning <input type="checkbox"/> Firefighter <input type="checkbox"/> Hairdresser/barber <input type="checkbox"/> Metal degreasing <input type="checkbox"/> Oil & gas <input type="checkbox"/> Painter <input type="checkbox"/> Road Construction <input type="checkbox"/> Textile Manufacturing <input type="checkbox"/> Welder <input type="checkbox"/> None of the Above <input type="checkbox"/> I do not know/do not recall

*Add'l Personal History*

Resume universal questions						
69. Please identify the highest academic degree claimant attained or <input type="checkbox"/> I do not know/do not recall.						
69a. Name of institution	69b. City, State	69c. Year attendance began	69d. Year attendance ended	69e. Degree attained (e.g., B.A., M.D., Ph.D.)	69f. Field of study	69g. Degree awarded?
<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	_____ YYYY <input type="checkbox"/> I do not know/do not recall	_____ YYYY <input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall
70. Did the Plaintiff ever possess an occupational certification or license?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall		
71. [If yes] What occupational certifications or licenses did the Plaintiff possess?						
72. Please identify all family grandparents, parents, siblings, or children of the Plaintiff who have ever been diagnosed with any of the disease identified on the Claimant's Short Form Complaint.						
72a. Name	72b. Relationship	72c. Year of birth	72d. Cancer or disease		72e. Year of diagnosis	
_____ <input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Grandparent <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Children <input type="checkbox"/> Other: _____ <input type="checkbox"/> I do not know/do not recall	_____ YYYY <input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Bladder cancer <input type="checkbox"/> Kidney cancer <input type="checkbox"/> Leukemia <input type="checkbox"/> Non-Hodgkin's lymphoma <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Other: _____		_____ YYYY <input type="checkbox"/> I do not know/do not recall	

## VI. ECONOMIC LOSS

Resume universal questions	
73. Are you seeking recovery for economic loss, such as out-of-pocket medical costs or lost earnings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Following questions available only if answer to Question 73 = "Yes"	
74. Has the Plaintiff ever paid or incurred any out-of-pocket <b>medical expenses</b> (i.e. expenses not paid by your insurance company or by a government health program) related to any condition caused by exposure to water at Camp Lejeune?	<input type="checkbox"/> Yes <input type="checkbox"/> No
75. Has the Plaintiff ever paid or incurred any out-of-pocket <b>non-medical expenses</b> (i.e. expenses not paid by your insurance company or by a government health program) related to any condition caused by exposure to water at Camp Lejeune?	<input type="checkbox"/> Yes <input type="checkbox"/> No
76. Has an injury related to Camp Lejeune water caused the Plaintiff to be unable to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## VII. PRIOR CLAIMS

Resume universal questions	
77. Did the Plaintiff (or someone else on the Claimant's behalf) ever file a civil litigation complaint against the United States related to contaminated water at Camp Lejeune before August 11, 2022?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall
Following questions available only if answer to question 77 = "Yes"	
78. What was the caption (the title or name) of the prior litigation?	
79. In what court was the prior litigation filed?	United States District Court for the _____ District of _____
80. What was the case number?	
81. Was the case consolidated in a multi-district litigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall
Back to universal questions	
82. Has the Plaintiff filed a bankruptcy petition since August 10, 2022?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall
Following questions available only if answer to question 82 = "Yes"	
83. On what date did the Plaintiff petition for bankruptcy?	_____ MM/DD/YYYY <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A
84. In what court did the Plaintiff file the bankruptcy petition?	United States Bankruptcy Court for the _____ District of _____
85. What is the case number for the Plaintiff's bankruptcy petition?	

Add'l Prior claims

Back to universal questions				
86. Has the Plaintiff ever filed a <b>disability</b> claim with a <b>state agency</b> for the injuries identified in the Short Form Complaint?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall	
87. [If yes] Please describe the nature of the disability claim and any award:				
87a. Name of agency where claim was filed	87b. Description of claim and disability	87c. Date claim was filed	87d. Whether Plaintiff was awarded disability	87e. Amount received in disability (or \$0 if none awarded)
		_____ MM/DD/YYYY  <input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall	\$ _____
		_____ MM/DD/YYYY  <input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall	\$ _____
		_____ MM/DD/YYYY  <input type="checkbox"/> I do not know/do not recall	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall	\$ _____
88. Did the Plaintiff (or someone else on the claimant's behalf) ever file a civil litigation complaint related to exposures to Agent Orange?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall	
89. [If yes] Please identify:				
89a. Case caption	89b. Court where the litigation was filed	89c. Case number	89d. Amount of compensation received from the lawsuit (or \$0 if none awarded)	
			\$ _____	
90. Did the Plaintiff (or someone else on the claimant's behalf) ever file a civil litigation complaint related to exposures to glyphosate (Round-Up)?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall	
91. [If yes] Please identify:				

91a. Case caption	91b. Court where the litigation was filed	91c. Case number	91d. Amount of compensation received from the lawsuit (or \$0 if none awarded)

**VIII. ADDITIONAL NOTES AND COMMENTS**

<u>Question No.</u>	<u>Comment</u>

**PLAINTIFF CERTIFICATION OF DPPF**

I, \_\_\_\_\_, certify that the information herein and/or supporting the attached Discovery Pool Profile Form is true and accurate to the best of my knowledge, information, and belief. I declare under penalty of perjury that the foregoing is true and correct.

\_\_\_\_\_  
[Plaintiff Name]

### INSERTS FOR ADDITIONAL INJURIES

*a) Injury [ ] – repeat questions for each injury asserted (if needed)*

<p>92. I am completing this section as it relates to:</p>	<div style="display: flex; flex-direction: column; gap: 5px;"> <input type="checkbox"/> Bladder cancer <input type="checkbox"/> Kidney cancer <input type="checkbox"/> Leukemia <input type="checkbox"/> Non-Hodgkin's lymphoma <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Adverse Birth Outcomes <input type="checkbox"/> ALS <input type="checkbox"/> Aplastic anemia or myelodysplastic syndromes <input type="checkbox"/> Bile duct cancer <input type="checkbox"/> Brain/CNS cancer <input type="checkbox"/> Breast cancer <input type="checkbox"/> Cardiac birth defects <input type="checkbox"/> Cervical cancer <input type="checkbox"/> Colorectal cancer <input type="checkbox"/> Gallbladder cancer <input type="checkbox"/> Hepatic steatosis <input type="checkbox"/> Hypersensitivity skin disorder <input type="checkbox"/> Infertility <input type="checkbox"/> Intestinal cancer <input type="checkbox"/> Non-cancer kidney disease <input type="checkbox"/> Leukemia <input type="checkbox"/> Liver cancer <input type="checkbox"/> Lung cancer <input type="checkbox"/> Multiple myeloma <input type="checkbox"/> Neurobehavioral effects <input type="checkbox"/> Non-cardiac birth defects <input type="checkbox"/> Ovarian cancer <input type="checkbox"/> Pancreatic cancer <input type="checkbox"/> Prostate cancer <input type="checkbox"/> Sinus cancer <input type="checkbox"/> Soft tissue cancer <input type="checkbox"/> Systemic sclerosis/scleroderma <input type="checkbox"/> Thyroid cancer <input type="checkbox"/> Other: _____ </div>
<p>93. Has a physician diagnosed the Plaintiff with this injury?</p>	<div style="display: flex; flex-direction: column; gap: 5px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A </div>
<p>94. If yes, when was Plaintiff first diagnosed this injury?</p>	<div style="display: flex; flex-direction: column; gap: 5px;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> MM/DD/YYYY <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A </div>



95. Name of physician that first diagnosed the Plaintiff?				_____ Name <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A			
96. Name of hospital or medical group of physician:				_____ Name <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A			
97. Do you allege that this Injury caused or contributed to the Plaintiff's death?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A			
98. List all treating physicians, name of medical group, and city, state where treatment was received. If none, check here: <input type="checkbox"/> No treatment.							
50a. First name, if known	50b. Middle Initial, if known	50c. Last name, if known	50d. Suffix, if known	50e. Medical Group	50f. City, State	50g. Year(s) of Treatment	50h. Was this covered by TRICARE
						_____ Years <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know/do not recall <input type="checkbox"/> N/A